IMPACT OF FAMILIARITY AND GENDER DIFFERENCES ON THE STIGMATISATION OF CHILDREN WITH MENTAL ILLNESS, AND THEIR PARENTS

CHEONG SAU KUAN
Department of Psychology, Sunway University College
No 5, Jalan Universiti, Bandar Sunway
46150 Petaling Jaya, Selangor Darul Ehsan, Malaysia
Tel: +60(3)74918622 Ext. 3857
Fax: +60(3)56358633
skcheong@sunway.edu.my

ABSTRACT

The aim of this study is to investigate the impact of familiarity and gender differences on the stigmatisation of children with mental illness, and their parents. A total of 234 participants took part in a study to ascertain stigmatisation of children with mental illness, and parents who have a child with mental illness. This study measured the attitudes of participants who have different levels of familiarity with the mentally-ill people and compared the attitudes of these people based on gender. All participants completed self-reported questionnaires about their attitudes towards stigmatisation and their levels of familiarity with people with mental illness. The results indicated that participants with a lower level of familiarity tended to have a higher level of segregation from children with mental illness. Females have a higher level of sympathy for parents who have a child with mental illness.

Key words: family stigma, stigma attribution, children mental illness, stigmatisation, attitudes

INTRODUCTION

Stigmatisation of mental illness is a rising concern in many countries around the world. With the increase in mental health problems, the issue of stigmatisation has become more urgent. Green-Shortridge, Britt and Castro (2007) in a recent investigation on military personnel find that stigmatisation of mental illnesses is a factor that discourages mentally ill patients from seeking help. They also indicate that patients tend to view stigmatisation as a personal threat to their self image and thus refuse to present themselves for treatment despite having symptoms of mental illness that may disrupt their daily functions. Thus, research in identifying the causes that contribute to stigmatisation is important to help curb issues arising from this concern. To date, most of the research on stigmatisation has focused on adults with mental illness but little research has been done on children with mental illness, and their parents. As there are limited studies conducted in Malaysia, this research is intended to evaluate the impact of familiarity and gender differences on the stigmatisation of children with mental illness, and parents who have a child with mental illness.

LITERATURE REVIEW

Stigmatisation stems from the concept of stereotyping in the field of social psychology. Stereotyping is forming beliefs and opinions about the characteristics, attributes and behaviours of members of various groups (Hilton & von Hippel as cited in Whitley & Kite 2006) either in a positive or a negative manner (Whitley & Kite 2006). Stereotyping allows us to categorise information about social groups which, in turn, helps cognitive beings to quickly generate their impressions and expectations of someone who falls into a certain category of a social group (Tversky & Kahneman 1983). Thus, stereotyping is an important tool that helps human beings to function in their daily lives but sometimes stereotyping may be faulty or inaccurate and may distort our perception of specific stereotyped groups.

The term *stigma* originates from an ancient Greek word meaning a visible mark placed on members of a tainted group (Goffman as cited in Hinshaw 2005). Corrigan and Penn (1999) define *stigma* as a form of negative stereotyping and the stigma of mental illness is a representation of an invalid and poor justification of knowledge that has led to discrimination. For the purpose of this study, the researcher investigated two areas of stigmatisation: (a) the stigmatisation of children with mental illness, and (b) the stigmatisation of parents who have a child with mental illness.

Several studies on stigmatisation have indicated that among many populations, there is stigmatisation of mental illness. Papadopoulos, Leavey and Vincent (2002) conducted a study to evaluate the differences in attitudes between first- and second-generation Greek-Cypriots and white English population towards stigmatisation. They find that the Greek-Cypriots have more beliefs of stigmatisation about mental illness than the white English. This study of 91 Greek-Cypriots and 79 white English has raised concerns about stigmatisation issues. Amongst the Asian communities, a survey conducted in Hong Kong reported high levels of stigmatisation of people with mental illness which has resulted in a great resistance to setting up psychiatric rehabilitation services and limiting employment opportunities for people with mental illness (Tsang, Tam, Chan & Cheung 2003).

Research by Martin, Pescosolido and Tuch (as cited in Dingfelder 2009) in the United States shows that the general public continue to stigmatise people with mental illness. Amongst the participants, 68% reported that they were unwilling to marry into a family with mental illness, 58% were unwilling to work closely with a mentally ill person and 56% were unwilling to spend an evening socialising with a mentally ill person. Results from the US National Stigma Study (Pescosolido as cited in Dingfelder 2009) suggest that children with mental health problems face less stigmatisation than adults with mental illness do but parents still fear having their children diagnosed. The results in the study report that over 40% of parents believed that seeking psychological help would result in their children being ostracised and that their children would face discrimination as adults when others find out about their history of mental health problems. More than 80% reported that their childhood depression was the fault of their parents. It is evident that stigmatisation is a rising concern and thus research in this area of study may yield important findings to help a mentally ill patient improve his condition.

Besides showing the association of mental illness with stigmatisation, the research also indicates that stigmatisation extends to the family as well. This is termed as *family stigma*. *Family stigma* is defined as stigmatisation towards families with children suffering from a mental illness (Corrigan & Miller 2004). Because of the stigmatisation of the mentally ill

person, the family may be ostracised by others. Mental illnesses taint the reputation of the family, and their relationships with friends and neighbours are jeopardised, leading to family stigma (Lefley 1989). According to Hinshaw (2005), parents of children with mental illness are often blamed for their child's condition, and thus shoulder a high proportion of family blame.

Corrigan, Miller and Watson (2006) in their nationwide survey of 968 participants indicate that families who have members with mental illness report experiencing more stigmatisation in comparison to families who have members with drug-dependent disorders or other health conditions. This family stigma has a great impact on parents of children with mental illness. In a study of 67 military parents with children suffering from mental illness, Sansone, Matheson, Gaither and Logan (2008) find that parents who have a child with a higher severe mental illness face greater stigma where their careers are concerned. These parents were concerned that their child's condition might jeopardise their career prospects. This research also shows the serious consequences when individuals with a mental illness, and their families are stigmatised.

The research also investigates the various factors that contribute to the stigmatisation of people with mental illness. One of the most discussed factors is the level of familiarity or contact with a mentally ill person. *Familiarity* is defined as the level of contact with a person having mental illness. This level of contact can range from intimate (personal experience with a person suffering from mental illness) to minimal intimacy (non-personal experience with a mentally ill person) (Holmes, Corrigan, Williams, Canar & Kubiak 1999).

An extensive review by Couture and Penn (2003) reveals evidence that familiarity is inversely proportionate to the degree of stigma attached to a person with mental illness. Their review includes previous research on retrospective and prospective contacts, indicating their level of familiarity with an individual with mental illness. A study by Alexander and Link (2003) reveals that participants who reported having a higher degree of familiarity with a person suffering from mental illness have lower perceptions of danger and desired social distance. The researchers divided familiarity into four types of contact levels (family, public, work, and friend/spouse) but there was no consistent predictor of the contact types on stigmatisation. In the Asian context, research by Tsang and his colleagues (2003) also find that familiarity encourages benevolence but those with mental illness are viewed as pitiful. However, the level of familiarity does not make a difference on the perception of hostility, nor on the rejection and fear of people with mental illness.

In an experimental research, Reinke, Corrigan, Leonhard, Lundin and Kubiak (2004) investigated the impact that different levels of contact with a mentally ill person have on stigmatisation. Their experiment focused on the different levels of contact (in vivo contact with moderate disconfirmation, and videotaped contact with moderate, high, low and no disconfirmation). Their results show a significant change in attitudes towards mental illness when there is a decrease in social distance, and both in-vivo and videotaped contacts yield significant changes when compared to the control group. Overall, research indicates that contact is an important contributor in moderating the stigmatisation of people with mental illness. Most research has focused on the impact of levels of contact on stigmatisation of the individual but not on family stigma. Thus, this current study is interested in comparing the levels of contact between children with mental illness and their families.

Besides the level of contact, some researchers have also investigated gender differences in the stigmatisation of people with mental illness. Gender differences may be evident due

to gender stereotyping. Findings from Deaux and Lewis (1984) indicate that in comparison to males, females play a more nurturing and less assertive role. Thus, when gender differences are considered in the stigmatisation of children with mental illness and their families, this may yield interesting findings.

A research on young Jamaicans finds that females have a stronger perspective that mental illness is due to a failure of will while males hold more benevolent opinions. However, no differences were reported for social restrictiveness (Jackson & Heatherington 2006). The same research also indicates that females show a sharp decrease in contact desire when they discover that the person present has a mental illness in comparison to males who only show a gradual decrease. In contrast, a separate study of 1601 Greek population reports that when compared to females, males have a more negative perspective of services provided by mentally ill person (Melissa et al. [n.d.]). In addition, the research also indicates that males are less likely to accept a person with mental illness into their work or social circle. These contradictory results of gender perspectives require further investigations.

The review of literature suggests that contact with a person suffering from mental illness is significant in affecting stigmatisation but there is inconclusive evidence of the impact of gender differences on stigmatisation. Thus, this study will focus on the impact of the levels of familiarity on stigmatisation, and gender differences in stigmatisation by young adults in Malaysia. This research hypothesises the following:

1. A higher level of familiarity with a person suffering from mental illness would lead to a lower level of stigmatisation of children with mental illness.
2. A higher level of familiarity with a person suffering from mental illness would lead to a lower level of stigmatisation of a parent who has a child with mental illness.
3. Males are more likely than females to stigmatise children with mental illness.
4. Males are more likely than females to stigmatise a parent who has a child with mental illness.

METHODOLOGY

Research Design

A single survey was carried out to obtain answers to the research questions. The participants were selected at random, depending on the participants' voluntary responses to the survey questionnaire. The questionnaire consists of general demographic enquiries, questions on the stigmatisation of children with mental illness, and their families. It also includes questions that measure the participants' levels of familiarity with people with mental illness.

Participants

There were 234 participants in the survey. The participants were between 18 and 25 years with a mean of 20.6 years. This survey targeted mainly students at the tertiary education

level and young working adults. This age group was selected for convenient sampling and the age limits allow better comparison. All the participants were chosen from the Klang Valley area. Amongst the participants, 51.7% were male, and 48.3% were female. In terms of ethnic distribution, the respondents were mostly Chinese (59.4%) followed by Indians (17.5%), Malay (10.3%), Bumiputra (2.1%) and others (10.7%). There was a fair distribution in the education levels of the participants, with 28.2% from the secondary education level or lower, 38.5% from the diploma level and 33.3% from the degree level or higher. The majority of the participants were students (81.6%) while 18% were from the working population with one exception: one participant (0.4%) was unemployed. All the demographic details are documented in Table 1.

Table 1. Participant Demography

	Statistics	
Categories/Groups	Number	Percentage (%)
Gender		
Male	121	51.7
Female	113	48.3
Ethnic		
Malay	24	10.3
Chinese	139	59.4
Indian	41	17.5
Bumiputra	5	2.1
Others	25	10.7
Education Level		
Secondary or lower	66	28.2
Diploma	90	38.5
Degree or higher	78	33.3
Job Category		
Student	191	81.6
Working adult	42	18.0
Unemployed	1	0.4

Measurement Device

Three measurement devices were used to assess the stigmatisation of children with mental illness, and their families as well as the levels of familiarity with people with mental illness. All the measurement devices were conducted in English and no translation was required. All the measurement devices are described in details below.

Attribution Questionnaire-Short Form for Children (AQ-SF) (Corrigan et al. 2000) measures the attribution of adults towards children with mental illness providing an indication of the stigmatisation of children with mental illness. A vignette describing a child with mental illness is provided. The measurement device measure eight items: *pity*, *danger*, *fear*, *responsibility*, *segregation*, *anger*, *refusal to help* and *avoidance*. The items

pity and *help* were inversely scored. Each individual item was scored on a Likert scale of 1 to 7, with **1** being **strongly disagree** and **7**, **strongly agree**. A higher value on each item indicates a higher level of stigmatisation of children with mental illness.

Family Stigma Questionnaire (FSQ) (Corrigan & Miller2004) was used to measure the adult's perception of families who have children with mental illness, thus providing an indication of the stigmatisation. A vignette describing a parent who has a child with mental illness is provided. The measurement device has seven items: *blame for onset*, *contamination*, *blame for offset* (re-emergent of symptoms), *shame/anger*, *incompetence*, *avoidance* and *pity.* Each individual item was scored on a Likert scale of 1 to 7, with **1** indicating **strongly disagree** and **7** indicating **strongly agree**. A higher score on each item indicates a higher representation of or a higher level of the stigmatisation of parents who have a child with mental illness.

Level of Familiarity Questionnaire (LOF) (Holmes et al. 1999) measures the levels of contact the participants previously had with a mentally ill individual. The measurement device consists of eleven questions indicating the varying degrees of intimate contact with a person with mental illness. The participants were required to indicate if they had previous encounters based on the situations listed in the questionnaire. Each item is assigned a rank order from 11 to 1, with **11** being **the highest level of contact** and **1** being **the lowest level of contact**. For the purpose of this research, the scores were divided into two categories. The first category is the lower familiarity indicating non-personalised contact and the second category is the higher familiarity where the respondents have had previous personal contacts with a person with mental illness. LOF ranks from **1** (*I have never observed a person whom I was aware has a severe mental disability.*) to **5**(*I have observed persons with a severe mental illness on a frequent basis.*) were placed under category one as these questions assess non-personalised contacts with a person with mental illness. LOF ranks from **6** (*I have worked with a person who has a severe mental illness at my place of employment.*) to **11** (*I have a severe mental disability.*) were put in category two which assesses personalised contacts with a person suffering from mental illness.

RESULTS

This research was carried out to ascertain the impact of familiarity on the stigmatisation of children with mental illness and a parent who has a child with mental illness. In addition, the research also investigated gender differences in the stigmatisation of children with mental illness and a parent who has a child with mental illness. To examine the difference in stigmatisation resulting from the higher and lower levels of familiarity, as well as from gender, the mean scores of each group were compared. Both categories of the levels of familiarity (low familiarity was 50.4% while high familiarity was 48.3%) and gender (51.7% males and 48.3% females) were fairly distributed.

Both the AQ-SF and FSQ do not have a total score, so the comparison was made based on individual items. An independent t-test was used to compare the levels of familiarity with the individual items of AQ-SF and FSQ. The results of the analyses indicate that there are no significant differences between the high and low levels of familiarity in all items of AQ-SF and FSQ with the exception of the item *segregation* from AQ-SF. The mean is

significantly greater in the low familiarity category (*M*=4.02, *SD*=2.35) than in the high familiarity category *(M*=3.19, *SD*=2.16), *t*(229) = 2.80, $p < .05$. This indicates that the participants who report a high level of familiarity would have less segregation from children with mental illness. The results are shown in Tables 2 and 3.

Table 2. Mean Difference between Levels of Familiarity on the Stigmatisation of Children with Mental Illness

Item	Mean (SD)		t-value
	Low familiarity	High familiarity	
Pity	3.72 (1.94)	3.49 (1.88)	0.93
Danger	4.74 (2.17)	4.53 (2.03)	0.75
Fear	4.16 (2.13)	3.98 (2.06)	0.65
Responsibility	2.23 (1.69)	2.17 (1.59)	0.28
Segregation	4.02 (2.35)	3.19 (2.16)	2.80*
Anger	2.36 (1.39)	2.51 (1.60)	0.76
Refusal to Help	3.86 (1.86)	3.67 (1.83)	0.79
Avoidance	3.42 (1.93)	3.35 (1.97)	0.27

Note: * =*p<0.05*

Table 3. Mean Difference between Levels of Familiarity on the Stigmatisation of a Parent Who Have a Child with Mental Illness

Items	Mean (SD)		t-value
	Low familiarity	High familiarity	
Blame for onset	3.58 (1.76)	3.56 (1.72)	0.12
Contamination	3.36 (1.95)	3.61 (2.03)	-0.97
Blame for offset	3.04 (1.32)	2.97 (1.45)	0.38
Shame / Anger	2.27 (1.45)	2.01 (1.42)	1.39
Incompetence	2.76 (1.24)	2.51 (1.33)	1.48
Avoidance	2.25 (1.10)	2.35 (1.38)	-0.61
Pity	4.73 (1.63)	5.09 (1.35)	-1.82

Note: No statistical significance on any items

To validate hypotheses 3 and 4, an independent t-test was carried out to compare the impact of gender differences on the stigmatisation of children with mental illness and parents who have a child with mental illness. An independent t-test was used to compare the gender with the individual items of AQ-SF and FSQ. The results of the analyses indicate that there are no significant differences between gender on all items in AQ-SF and FSQ with the exception of the item *pity* from FSQ. The mean is significantly greater for females (*M*=5.10, *SD*=1.44) than for males *(M*=4.64, *SD*=1.54), *t*(232) = -2.86, $p < .05$. This shows that the female participants have a higher level of pity for families who have a

child with mental illness than the male participants do. The results are detailed in Tables 4 and 5.

Table 4. Mean Difference between Genders on the Stigmatisation of Children with Mental Illness

Item	Mean (SD)		t-value
	Male	Female	
Pity	3.69 (1.96)	3.50 (1.84)	0.76
Danger	4.69 (2.15)	4.67 (2.11)	0.05
Fear	3.93 (2.05)	4.34 (2.20)	-1.48
Responsibility	2.29 (1.69)	2.09 (1.57)	0.94
Segregation	3.72 (2.37)	3.59 (2.27)	0.42
Anger	2.49 (1.51)	2.40 (1.51)	0.45
Refusal to Help	3.94 (1.85)	3.59 (1.84)	1.15
Avoidance	3.58 (2.06)	3.29 (1.91)	1.10

Note: No statistical significance on any items

Table 5. Mean Difference between Genders on the Stigmatisation of a Parent Who Have a Child with Mental Illness

Item	Mean (SD)		t-value
	Male	Female	
Blame for onset	3.61 (1.87)	3.54 (1.59)	0.32
Contamination	3.37 (2.01)	3.60 (1.96)	-0.88
Blame for offset	3.01 (1.38)	3.01 (1.39)	-0.03
Shame / Anger	2.26 (1.58)	2.10 (1.34)	0.83
Incompetence	2.74 (1.35)	2.51 (1.20)	1.38
Avoidance	2.40 (1.35)	2.22 (1.12)	1.08
Pity	4.64 (1.54)	5.10 (1.44)	-2.86*

Note: * $=p<0.05$

In conclusion, hypotheses 1 and 4 are partially accepted but hypotheses 2 and 3 are rejected as no statistical significance was obtained.

DISCUSSION

This study was designed to evaluate stigmatisation by the general population. It was hypothesised that higher levels of familiarity with a person with mental illness would lead to a lower level of stigmatisation of children with mental illness and a parent who has a child with mental illness. In addition, the researcher was also interested in investigating the possible gender differences on stigmatisation.

Firstly, the results of this study only show there is a significant difference between the levels of familiarity only from the perspective of segregating children with mental illness. Participants who have a lower level of familiarity (those who have not experienced personal contact with individuals having mental illness) think that children with mental illness should be segregated from others and be placed in an institution. Secondly, there is a significant difference between males and females in showing pity towards a parent who has a child with mental illness. In comparison to males, females show a higher level of pity for parents who have a child with mental illness.

The results are consistent with previous experimental research in that a lower intimacy of contact was related to a higher level of stigmatisation (Reinke et al. 2004). However, this contradicts the results of Alexander and Link (2003) which indicate familiarity as a predictor of danger and social distance. This research does not show any significant results in danger and social distance (as measured in the item *avoidance* on both AQ-SF and FSQ).

There were also no major differences in the results from gender comparison. The differences in pity between the genders may be a reflection of the more nurturing role of the female, as described by Deaux and Lewis (1984). The vignette describes a mother who has to care for her child with mental illness. This may have triggered higher levels of pity because the female participants may have assumed that the mother has to shoulder the full responsibility of the care of the child. In future research, care should be taken when assigning gender to the parents in the vignette.

It is important that the results from this study create awareness within the community of the stigma attached to children with mental illness as well as a parent who has a child with mental illness. The research results show that the sample population in this research do not display high levels of stigmatisation towards children with mental illness, and parents who have a child with mental illness. The results are in line with the US National Stigma Survey (Pescosolido as cited in Dingfelder 2009) which indicates lower stigmatisation of children with mental illness. However, the results of this study cannot be applied to the general population nationwide as the sample size was relatively small and most of the samples were drawn from a student population in an urban environment. This could have skewed the results because the respondents may have a higher level of exposure and thus increased knowledge. Papadopoulos and colleagues (2002) find that participants with a higher level of knowledge and contact with the mentally ill are significantly more likely to have non-negative attitudes towards this group.

The current research may not reveal alarming indicatives of stigmatisation of mentally ill children and parents with mentally ill children but anti-stigmatisation programmes are important to educate future population. Corrigan and Penn (1999) explain that there are three strategies to reduce stigmatisation of mental illness by the public. Firstly, anti-stigmatisation campaigns can be carried out by advocacy groups to protest against inaccurate information and hostile representations of mental illness. This method has two messages: (i) it tells the media to stop giving inaccurate representations of mental illness and (ii) it tells the public not to believe in inaccurate information about mental illness. Despite its efficacy, a protest is merely a reaction to a situation one is presented with. Thus, by protesting, one is rejecting the situation emotionally but it does not teach others appropriate behaviours that may help to inculcate positive attitudes.

Thus, Corrigan and Penn (1999) suggest that education is required to ensure accurate representation. Accurate representation allows the public to reshape their cognitive

structure which alters stereotyping. With accurate information, one is able to make better decisions on future behaviour. However, information only serves as a guideline for identification and awareness but this is still insufficient to elicit behavioural change. The researchers then suggest that face-to-face contacts would provide the basis to practise the knowledge acquired. Behavioural change will be more prominent when all three levels are enforced.

Altindag, Yanik, Ucok, Alptekin and Ozkan (2006) adapted part of the model suggested by Corrigan and Penn (1999) in an experiment with first-year medical students. They conducted a one-day programme that included a two-hour lecture on schizophrenia, followed by a face-to-face discussion with a young person having schizophrenia, and lastly a film on a schizophrenic person (*A Beautiful Mind*). The one-day programme yielded a positive change in the attitudes of the participants towards people with schizophrenia before and after the programme. The same was observed in the control group.

Similarly, Spagnolo, Murphy and Librera (2008) also adopted the same strategy to study behavioural change towards individuals with mental illness. They carried out a one-hour informational session that presented information on mental illness which included information from mental health service consumers, and personal stories about recovery. The results show a reduction in the stigmatisation of individuals with mental illness. Thus, both research indicates that strategies provided by Corrigan and Penn (1999) have proven to be effective in reducing stigmatisation.

Given the findings and limitations of this study, it would be necessary to conduct further research that expands the investigation of other factors contributing to stigmatisation. A further investigation of the various socio-economic groups, the information levels on mental illness or the education levels of the participants may provide a deeper insight on stigmatisation. In conclusion, this research provides some understanding of the stigmatisation by a certain segment of the general population towards children with mental illness and their parents.

CONCLUSION

In conclusion, this research was aimed at finding the impact of familiarity and gender on the stigmatisation of children with mental illness and their parents. The results only show that there is obvious stigmatisation in segregation by those who have less familiarity with mentally ill children. It also shows that when compared to males, females have a higher level of pity. Despite the results, measures can be taken to further reduce the stigmatisation of children with mental illness, and their parents. This is important as stigmatisation is a strong deterrent factor amongst patients with mental illness in seeking treatment

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